Maine Bureau of Insurance

Form Filing Review Requirements Checklist

LARGE GROUP ONLY - HMO/POS PLANS - HOrg02G

(NON-GRANDFATHERED)

For Plans Issued On or After January 1, 2019

(Revised 9/27/2018)

Carriers must confirm compliance and IDENTIFY the LOCATION (Page number, Section, Paragraph, etc.) of the standard in the form in the last column. N/A: Check this box if a contract does not have to meet this requirement carriers must EXPLAIN WHY in the last column.

State Benefit/Provision and/or ACA Requirement	State Law/ Rule and/or Federal Law	State Description of Requirement and/or ACA Description of Requirement	N/A →	CONFIRM COMPLIANCE AND IDENTIFY LOCATION OF STANDARD IN FILING MUST EXPLAIN IF REQUIREMENT IS INAPPLICABLE
GENERAL SUBMISSION REQUIREMENTS				
Electronic (SERFF) Submission Requirements	24-A M.R.S. §2412 (2) Bulletin 360	All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF). See http://www.serff.com.	☐	
FILING FEES	24-A M.R.S.A. §601(17)	$20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report.	☐	
Grounds for disapproval	24-A M.R.S.A. §2413	Seven categories of the grounds for disapproving a filing.	☐	
Readability	24-A M.R.S.A. §2441	Minimum of 50. Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities	☐	

		as funding vehicles. Scores must be entered on form schedule tab in SERFF.		
Variability of Language	24-A M.R.S.A. §2412 §2413	Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations.	☐	
GENERAL POLICY PROVISIONS				
Applicant's statements	24-A M.R.S.A. §2817	No statement made by the applicant for insurance shall void the insurance or reduce benefits unless contained in the written application signed by the applicant; and a provision that no agent has authority to change the policy or to waive any of its provisions; and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
Continuity	24-A M.R.S.A. §4222-B Chapter 36	This section provides continuity of coverage for a person who seeks coverage under an individual or a group insurance policy or health maintenance organization policy.	☐	
Continuity of Care	24-A M.R.S.A. §4303(7)	If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C.	☐	
Continuation of group coverage	24-A M.R.S.A. §2809-A(11)	If the termination of an individual's group insurance coverage is a result of the member or employee being temporarily laid off or losing employment because of an injury or disease that the employee claims to be compensable under Workers Compensation, the insurer shall allow the member or employee to elect to continue coverage under the group policy at no higher level than the level of benefits or coverage received by the employee immediately before termination and at the	☐	

		member's or employee's expense or, at the member's or employee's option, to convert to a policy of individual coverage without evidence of insurability in accordance with this section.		
Continuity on replacement of group policy	24-A M.R.S.A. §2849	This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy.	☐	
Coordination of Benefits	Rule 191(§9-A and §9-D) Rule 790	Section 9(D) states: Evidences of coverage may contain a provision for coordination of benefits, provided that such provision shall not relieve an HMO of its duty to provide or arrange for a covered health care service to an enrollee solely because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. Coordination with Medicare is permitted under the same conditions and manner applicable to non-HMO plans and described in 24-A M.R.S. §§ 2844 and 2723-A. Medicaid is always secondary.	☐	
Definition of Medically Necessary	24-A M.R.S.A. §4301-A, Sub-§10-A	Forms that use the term "medically necessary" or similar terms must include the following definition verbatim: A. Consistent with generally accepted standards of medical practice; B. Clinically appropriate in terms of type, frequency, extent, site and duration; C. Demonstrated through scientific evidence to be effective in improving health outcomes; D. Representative of "best practices" in the medical profession; and E. Not primarily for the convenience of the enrollee or physician or other health care practitioner.	☐	
Designation of Classification of Coverage	24-A M.R.S.A. §2694 Rule 755, Sec. 6	The heading of the cover letter of any form filing subject to this rule shall state the category of coverage set forth in 24-A M.R.S.A. §2694 that the form is intended to be in. **(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)**	☐	
Evidence of Coverage	24-A M.R.S.A. §4207	Every person who has enrolled as a legal resident of this State in a health maintenance organization is entitled to evidence of coverage.	☐	

	Rule 191§9	No evidence of coverage, or amendment thereto, or underlying contract may be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, amendment thereto and any underlying contract, has been filed with and approved by the superintendent. An evidence of coverage shall contain: A. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in section 4212; and [1975, c. 503, (NEW).] B. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of: (1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled; (2) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature; (3) Where and in what manner information is available as to how services may be obtained; (4) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts or an indication whether the plan is contributory or noncontributory with respect to group certificates; and (5) A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints. Any subsequent change shall be evidenced in a separate document issued to the enrollee prior to the change.		
Explanations for any Exclusion of Coverage for work related sicknesses or injuries	24-A M.R.S.A. §2413	If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws.	☐	

Explanations Regarding Deductibles	24-A M.R.S.A. §2413	All policies must include clear explanations of all of the following regarding deductibles: 1. Whether it is a calendar or policy year deductible. 2. Clearly advise whether non-covered expenses apply to the deductible. 3. Clearly advise whether it is a per person or family deductible or both.	☐	
	45 CFR § 156.130(b)	Cost sharing for non-calendar plans accrues for a 12-month period, and ensuring that an enrollee only has to accumulate cost sharing towards one annual limitation on cost sharing. The annual limitation cost sharing is to apply on an annual basis regardless of whether it is a calendar year or a non-calendar year plan. On exchange SHOP plans must operate on a calendar year plan. Off exchange SHOP plans can operate on a plan year.		
High Deductible Plans & HSAs	45 CFR § 156.130	Family high deductible health plans that count the family's cost sharing to the deductible limit can continue to be offered under this policy. The only limit will be that the family high deductible health plan cannot require an individual in the family plan to exceed the annual limitation on cost sharing for self-only coverage.		
Extension of Benefits	24-A M.R.S.A. §2849-A	Provide an extension of benefits of 6 months for a person who is totally disabled on the date the group or subgroup policy is discontinued. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement. For purposes of determining eligibility for extension of benefits, "total disability" shall be defined no more restrictively than:	☐	

		A. in the case of an insured who was gainfully employed prior to disability, "the inability to engage in any gainful occupation for which he or she is reasonably suited by training, education, and experience;" or B. in the case of an insured who was not gainfully employed prior to disability, "the inability to engage in most normal activities of a person of like age in good health." ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***		
Genetic information (GINA), coverage is not based on	PHSA §2753 (74 Fed Reg 51664, 45 CFR §148.180)	An issuer is not allowed to: Adjust premiums based on genetic information; Request /require genetic testing; Collect genetic information from an individual prior to/in connection with enrollment in a plan, or at any time for underwriting purposes.	☐	
Grace Period	24-A M.R.S.A. §4209 (6) Bulletin 288	30 or 31 days.	☐	
Guaranteed Issue & Renewal	24-A M.R.S.A. §2808-B §2736-C	Small group plans are guaranteed issue and renewed, community rated, and standardized plans. Requires guaranteed issue and renewal.	☐	
Guaranteed Renewal	24-A M.R.S.A. §2850-B	Renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except for failure to pay premiums, fraud or intentional misrepresentation.	☐	
Health plan accountability	Rule 850	Standards in this rule include, but are not limited to, required provisions for grievance and appeal procedures, emergency services, access and utilization review standards.	☐	
Limitations & Exclusions	Rule 191, Sec. (9)(N)	A plan may contain exclusions approved by the Superintendent that are not otherwise prohibited by state or federal law, rule, or regulation. Unless otherwise directed by the Superintendent, HMO plans may contain exclusions similar to exclusions permitted in non-HMO plans that provide Essential Healthcare Benefits in accordance with the Affordable Care Act.	☐	

Notice of Policy Changes and Modifications Notice of Policy Changes	24-A M.R.S.A. §2850(B)(3)(I) PHSA 2715 (75 Fed Reg 41760)	A carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. Provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits.	☐	
Notice of Rate Increase	24-A M.R.S.A. §4222-B(15),	Requires that insurers provide a minimum of 60 days written notice to affected policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. It specifies the requirements for the notice. See these sections for more details. Reasonable notice must be provided for other types of policies.	☐	
Penalty for failure to notify of hospitalization	24-A M.R.S.A. §2847-A 45 CFR §147.138(b)	No penalty for hospitalization for emergency treatment. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
Pre-existing condition exclusions	PHSA §2704 PHSA §1255 (75 Fed Reg 37188, 45 CFR §147.108)	Prohibits the imposition of a preexisting condition exclusion by all group plans and nongrandfathered individual market plans.	☐	
Prohibited practices Rescissions prohibited	24-A M.R.S.A. §2736-C(3)(A) 2850-B(3) PHSA§2712 (75 Fed Reg 37188,	An enrollee may not be cancelled or denied renewal except for fraud or material misrepresentation and/or failure to pay premiums for coverage. Rescissions are prohibited except in cases of fraud or intentional misrepresentation of material fact. Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected.	☐	

	45 CFR §147.128)			
Prohibition against Absolute Discretion Clauses	24-A M.R.S.A. §4303(11)	Carriers are prohibited from including or enforcing absolute discretion provisions in health plan contracts, certificates, or agreements.	☐	
Prohibition on Discrimination	45 CFR §156.1259(a)	An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.	☐	
Rates - Small Group	24-A M.R.S.A §2808-B (2-A)	A policy of group or blanket health insurance may not be delivered in this State until a copy of the rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care insurance contracts and for certain association groups and other groups specified in section 2701, subsection 2, paragraph C must be filed in accordance with section 2736. Rates for small group health insurance subject to section 2808-B are subject to the additional filing requirements specified in that section. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. **PLEASE NOTE: Rates must be filed in the same filing as the forms. Forms submitted without rates will be rejected. Please review the general information page on SERFF for further information on form and rate filings. If forms are being revised and there is no effect on current rates, please indicate so in the filing cover letter and reference the previously approved rate filing in the Corresponding Filing Tracking Number field.**	☐	

Rebates	§2160 §2163-A Bulletin 382	Are there any provisions that give the insured a benefit not associated with indemnification or loss?" Yes ___ No ___	☐	
Renewal of policy	24-A M.R.S.A. §4207 Rule 191(9)(G) §2820	There shall be a provision stating the conditions for renewal.	☐	
Representations in Applications	24-A M.R.S.A. §2818	There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
Required disclosures (Summary of Benefits and Coverage)	PHSA §2715 45 CFR §147.200 24-A M.R.S.A. §4303(15)	All insurers must provide a Summary of Benefits and Coverage and Uniform Glossary to enrollees. Please see http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html for forms and instructions. A carrier offering a health plan in this State shall: A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act; and B. Use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal Affordable Care Act.	☐	

Third Party 10 Day Notice of Cancellation Due to Cognitive Impairment or Functional Incapacity	24-A M.R.S.A. §2847-C Rule580	An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance policy for nonpayment of premium. Insurers must provide the following disclosure, notice and reinstatement rights: 1. Insured has the right to elect a third party to receive notice and that the insurer will send them a third party notice request form to make that selection. 2. Insured and designated individual will receive a 10 day notice of cancellation. 3. Insured has the right to reinstatement of the contract if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured. 4. Notice that if a request for reinstatement of coverage because of cognitive impairment or functional incapacity is denied, notice of denial shall be provided to the insured and to the person making the request, if different. The notice of denial shall include notification of the 30 day period following receipt of the notice during which a hearing before the Superintendent may be requested. **FOR GROUP PLANS**: Third Party Notice of Cancellation for group plans must be applied as follows: 1. If the entire cost of the insurance coverage is paid by the Policyholder, there is no requirement to send the Third Party Notice of Cancellation. 2. If the entire cost of the insurance coverage is paid by the Certificateholder and is direct billed, the insurer must include notification in the policy/certificate to advise the member of their rights.	☐	

		3. If the entire cost of the insurance coverage is paid by the Certificateholder and is made via payroll deduction, then Rule 580, Sec. 5 (3) would apply and the insurer must include this notification in the policy/certificate to advise the member of their rights. 4. If a portion of the cost of the insurance coverage is paid by the Policyholder and the remainder is paid by the Certificateholder and is made via payroll deduction, then Rule 580, Sec. 5 (3) would apply and the insurer must include this notification in the policy/certificate to advise the member of their rights. Therefore, please review Rule 580 and add the required language to the certificate. Additionally, pursuant to Rule 580 Sec. 6(A)(7), the requirement may be satisfied by including the notice of reinstatement right in an application that is incorporated into the contract.		
Time for suits	24-A M.R.S.A. §2828	There shall be a provision that from the date of issue of a policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such 2-year period.	☐	
ADDITIONAL STATE REQUIREMENTS NOT REQUIRED IN POLICY/CERTIFICATE				

Health care price transparency tools; website, toll-free telephone number, and cost estimates	24-A M.R.S. § 4303(21)	A carrier offering a health plan in this State shall comply with the following requirements. A. **A carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number** that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in Title 24-A, section 4318-A, subsection 1, paragraph A *(referenced below)*, from network providers, as well as quality data for those providers, to the extent available. **A carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the Maine Health Data Organization**. B. **A carrier shall make available to the enrollee the ability to obtain an estimated cost** that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider. Upon an enrollee's request, the carrier shall request additional or clarifying code information, if needed, from the provider involved with the comparable health care service. If the carrier obtains specific code information from the enrollee or the enrollee's provider, the carrier shall provide the anticipated charge and the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider. C. A carrier shall notify an enrollee that the amounts are estimates based on information available to the carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed comparable health care service. This subsection does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed comparable health care service or for a procedure or service that was not included in the original estimate. This subsection does not preclude an enrollee from contacting the	☐	

	24-A M.R.S. § 4318-A(1)(A)	carrier to obtain more information about a particular admission, procedure or service with respect to a particular provider. "Comparable health care service" means nonemergency, outpatient health care services in the following categories: (1) Physical and occupational therapy services; (2) Radiology and imaging services; (3) Laboratory services; and (4) Infusion therapy services.		
ELIGIBILITY/ENROLLMENT				
Child-Only coverage	ACA 1302(d), PHSA §2707(c), (45 CFR §156.200(c)(2))	Must provide the same level of coverage, as described in the Affordable Care Act, to individuals who, as of the beginning of the plan year, have not attained the age of 21. The carrier does not need to file a separate child-only plan. The carrier may provide the following notice predominantly displayed on the first page of the policy: "THIS [POLICY OR CERTIFICATE] IS ALSO AVAILABLE AS A CHILD ONLY [POLICY OR CONTRACT].	☐	
Children (Newborn) Coverage	24-A M.R.S.A. §4234-C Rule 191, Sec. 9(M)	Newborns are automatically covered under the plan from the moment of birth for the first 31 days including coverage for congenital defects and birth abnormalities.	☐	
Children of Unmarried Women	24-A M.R.S.A. §4234(2)	Coverage of children must be made available to unmarried women on the same basis as married women.	☐	
Dependent children with mental or physical illness	24-A M.R.S.A. §4233-A PHSA §2728	Requires health insurance policies to continue coverage for dependent children up to the age at which coverage for students terminates under the terms of the policy who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility.	☐	

Dependent student on medically necessary leave of absence	(45 CFR §147.145)	Issuer cannot terminate coverage of dependent student due to a medically necessary leave of absence before: • The date that is 1 year after the first day of the leave; or • The date on which coverage would otherwise terminate under the terms of the coverage. "Medically necessary leave of absence" means: a leave of absence or change of enrollment of a dependent child from a post-secondary education institution that: 1. Commences while the child is suffering from a serious illness or injury; 2. Is medically necessary; and 3. Causes the child to lose student status for purposes of coverage under the terms of coverage. Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the terms for continued coverage during medically necessary leaves of absence.		
Dependent coverage	24-A M.R.S.A. §2809	May not use residency as a requirement for dependents. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
Dependent special enrollment period	24-A M.R.S.A. §4222-B(11) §2834-B	Enrollment for qualifying events.	☐	
Domestic Partner Coverage	24-A M.R.S.A. §4249	Coverage must be offered for domestic partners of individual policyholders or group members. This section establishes criteria defining who is an eligible domestic partner.	☐	
Extension of dependent coverage to age 26	24-A M.R.S.A. §4320-B	A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act.	☐	

Dependent coverage must be available up to age 26 if policy offers dependent coverage.	PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)	An insurer shall provide notice to policyholders regarding the availability of dependent coverage under this section upon each renewal of coverage or at least once annually, whichever occurs more frequently. Notice provided under this subsection must include information about enrolment periods and notice of the insurer's definition of and benefit limitations for preexisting conditions. Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: financial dependency on primary subscriber, residency, student status, employment, eligibility for other coverage, marital status. Terms of the policy for dependent coverage cannot vary based on the age of a child.		
Individual certificates	24-A M.R.S.A. §4207 Rule 191(9)	There shall be a provision that the insurer shall issue to the policyholder, for delivery to each member of the insured group, an individual certificate or printed information setting forth in summary form a statement of the essential features of the insurance coverage of such employee or such member and in substance the provisions of sections 2821 to 2828. The insurer shall also provide for distribution by the policyholder to each member of the insured group a statement, where applicable, setting forth to whom the benefits under such policy are payable. If dependents are included in the coverage, only one certificate or printed summary need be issued for each family unit.	☐	
CLAIMS & UTILIZATION REVIEW				
Assignment of benefits	24-A M.R.S.A. §4207-A §2827-A Rule 191, Sec 9(C)(6) §4207-A(5-A)	All policies providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under Section 9(C) does not affect or limit the payment of benefits otherwise payable under the policy. All point-of-service contracts and certificates must contain a provision permitting the insured to assign any benefits provided for medical or	☐	

		dental care on an expense-incurred basis to the provider of the care. An assignment of benefits under this subsection does not affect or limit the payment of benefits otherwise payable under the contract or certificate.		
Calculation of health benefits based on actual cost	24-A M.R.S.A. §2185	Policies must comply with the requirements of 24-A §2185 which requires calculation of health benefits based on actual cost. All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized.	☐	
Claims for Office Visits that include Preventive Health Services	45 CFR §147.130 (a)(1)	Policies and certificates must include clear explanations regarding how claims will be paid for office visits that include preventive health services, and the policyholder's cost sharing may not be greater than the following: If an item or service described in 45 CFR §147.130 (a)(1): 1. Is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. 2. Is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.	☐	

		3. Is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.		
Credit toward Deductible	24-A M.R.S.A. §4222-B(21)	When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.	☐	
Denial of referral by out-of-network provider prohibited	24-A M.R.S. § 4303(22) Bulletin 430	A carrier may not deny payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a provider who is not a member of the carrier's provider network.	☐	
Examination, autopsy	24-A M.R.S.A. §2826	There shall be a provision that the insurer has the right to examine the insured as often as it may reasonably require during the pendency of claim and also has the right to make an autopsy in case of death where it is not prohibited by law. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
Explanation and notice to parent	24-A M.R.S.A. §4222-B(22) §2823-A	If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with: An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent; An explanation of any proposed change in the terms and conditions of the policy; Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified. In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	

Forms for proof of loss/Claim Forms	24-A M.R.S.A. §4207 Rule 191(9)(C)(3)	There shall be a provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the insurer received notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.	☐	
Lifetime Limits and Annual Aggregate Dollar Limits Prohibited Lifetime or annual limits on the dollar value of Essential Health Benefits (EHB): **<u>*2019 Plan Year Limits:</u>** OOP: IND: **$7900** FAMILY: **$15800**	24-A M.R.S.A. §4318 §4320 PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	An individual or group health plan may not include a provision in a policy, contract, certificate or agreement that purports to terminate payment of any additional claims for coverage of health care services after a defined maximum aggregate dollar amount of claims for coverage of health care services on an annual, lifetime or other basis has been paid under the health plan for coverage of an insured individual, family or group. A carrier may however offer a health plan that limits benefits under the health plan for specified health care services on an annual basis. Plans may not establish lifetime limits on the dollar value of essential health benefits: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance use disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care	☐	

		Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply.		
Limitations on Cost Sharing	45 CFR § 156.130	The annual limitation on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only. In both of these cases, an individual's cost sharing for EHB may never exceed the self-only annual limitation on cost sharing.	☐	
Limits on priority liens/Subrogation	24-A M.R.S.A. §4243	Does this policy have subrogation provisions? If yes see provision below: Subrogation requires prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. Applies to point of service contracts in the HMO but doesn't apply to closed network arrangements.	☐	
Notice of claim	24-A M.R.S.A. §4207 §2823 Rule 191(9)(C)(3)	There shall be a provision that written notice of sickness or of injury must be given to the insurer within 30 days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.	☐	
Payment of Claims	24-A M.R.S.A. §4207 Rule 191(9)(C)(4) §2436 §4222-B(13)	A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer.	☐	
Penalty for noncompliance with utilization review	24-A M.R.S.A. §2847-D	May not have a penalty of more than $500 for failure to provide notification under a utilization review program. ***(There is no specific***	☐	

		HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)		
Protection from Surprise Bills	§4303-C	In the event of a "surprise bill," a carrier shall reimburse an out-of-network provider at the average network rate under an enrollee's plan unless the carrier and provider agree otherwise, and the enrollee is only responsible for what he/she would have paid for a network provider. Notwithstanding that requirement, if a carrier has an inadequate network as determined by the superintendent, then the carrier must ensure that the enrollee obtains the service at no greater cost than if the service were obtained in-network, or make other arrangements acceptable to the superintendent A "surprise bill" is defined as a bill for health care services, other than emergency services, received by an enrollee for services rendered by an out-of-network provider at a network provider during a service or procedure performed by a network provider, or during a service or procedure previously approved or authorized by the carrier. A "surprise bill" does not include a bill for health care services received by an enrollee if a network provider was available and the enrollee knowingly elected to obtain the services from an out-of-network provider.	☐	
UCR Definition, Required Disclosure, Protection from Balance Billing by Participating Providers	24-A M.R.S.A. §4204(6) §4303(8) & (8-A) Rule 850 Sec. 7, Sub-Sec. B (5)	The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred. **Maximum allowable charges.** All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following. A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:	☐	

		(1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and (2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. **Protection from balance billing by participating providers.** An enrollee's responsibility for payment under a managed care plan must be limited as provided in this subsection. A. The terms of a managed care plan must provide that the enrollee's responsibility for the cost of covered health care rendered by participating providers is limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance, and that if the enrollee has paid the enrollee's share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care.		
Utilization Review & Notice Requirements for Health Benefit Determinations	24-A M.R.S.A. §4304 §4303(16)	**Initial determinations**: Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. **Urgent care determinations**:		

		Determination (whether adverse or not) and notify the covered person no later than 48 hours after receiving all necessary information. Carrier or the carrier's designated URE shall make a good faith effort to obtain all necessary information expeditiously, and is responsible for expeditious retrieval of necessary information in the possession of a person with whom the health carrier contracts. **<u>Concurrent review determinations</u>**: Determination shall be within 1 working day after obtaining all necessary information. Certification of Extended stay or additional services: Shall notify the covered person and the provider rendering the service within 1 working day. Written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services. Adverse benefit determination of concurrent review the carrier shall: Notify the covered person and the provider rendering the service within 1 working day. Continue the service without liability to the covered person until the covered person has been notified of the determination **<u>Utilization Review Disclosure Requirements</u>** The carrier shall include a clear and reasonably comprehensive description of its utilization review procedures, including: • Procedures for obtaining review of adverse benefit determinations; • A Statement of rights and responsibilities of covered persons with respect to those procedures in the certificate of coverage or member handbook; • The statement of rights shall disclose the member's right to request in writing and receive copies of any		

	Bulletin 397	clinical review criteria utilized in arriving at any adverse health care treatment decision. • Carrier shall include a summary of its utilization review procedures in materials intended for prospective covered persons; • Carriers requiring enrollees to initiate utilization review provide on its membership cards a toll-free telephone number to call for utilization review decisions. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act. Notices advising enrollees that services have been determined to be medically necessary must also advise whether the service is covered. Once a service has been approved, the approval cannot be withdrawn retrospectively unless fraudulent or materially incorrect information was provided at the time prior approval was granted. Also, if benefits are denied and the enrollee appeals, the carrier cannot deny the appeal without a written explanation addressing the issues that were raised by the enrollee.		
GRIEVANCES & APPEALS				
External review requests	24-A M.R.S.A. §4312 Rule 850	An enrollee is not required to exhaust all levels of a carrier's internal grievance procedure before filing a request for external review if the carrier has failed to make a decision on an internal grievance within the time period required, or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law, or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal. Claimant must have at least 1 year to file for external review after receipt of the notice of adverse benefit determination.	☐	

Grievance and appeals procedures	24-A M.R.S.A. §4303(4) Rule 850 Sec. 8 & 9	The policy must contain the procedure to follow if an insured wishes to file a grievance regarding policy provisions or denial of benefits. Specifically describe grievance & appeal procedures required in the contract, as well as the required available external review procedures. **All policies must contain all grievance and appeal procedures as referenced in Rule 850:** **First Level Appeals of Adverse Health Care Treatment Decisions:** • Carrier must allow the covered person to review the claim file and to present evidence and testimony as part of the internal appeals process. • Carrier must provide the covered person, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond. • Before a carrier can issue a final internal adverse benefit determination based on a new or additional rationale, the covered person must be provided with the rationale, free of charge, sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond. • The carrier must provide the covered person the name, address, and telephone number of a person designated to coordinate the appeal on behalf of the health carrier. • The carrier must make the rights in this subparagraph known to the covered person within 3 working days after receiving an appeal. • Appeals shall be evaluated by an appropriate clinical peer or peers. o The clinical peer/s shall not have been involved in the initial adverse determination, unless the appeal presents additional information the decision maker was unaware of at the time of rendering the initial adverse health care treatment decision. o The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.	☐	

		Standard appeals:
		
		• Shall notify in writing both the covered person and the attending or ordering provider of the decision within 30 days following the request for an appeal.
		• Additional time is permitted where the carrier can establish the 30-day time frame cannot reasonably be met due to the carrier's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier.
		  o Shall provide written notice of the delay to the covered person and the attending or ordering provider.
		  o The notice shall explain the reasons for the delay. In such instances, decisions must be issued within 30 days after the carrier's or designee's receipt of all necessary information.
		
		Expedited Appeals:
		
		• Expedited appeals shall be evaluated by an appropriate clinical peer or peers.
		  o The clinical peer/s shall not have been involved in the initial adverse health care treatment decision.
		  o The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.
		• Shall provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility.
		• Shall transmit all necessary information between the carrier or the carrier's designated URE and the covered person or the provider by telephone, facsimile, electronic means or the most expeditious method available.
		• Shall make a decision and notify the covered person and the provider via telephone within 72 hours after the review is initiated.		

		• If the initial notification was not in writing, the carrier shall provide written confirmation of its decision concerning an expedited review within 2 working days. • An adverse decision shall contain the notice requirements of an adverse health care treatment decision as set forth in Rule 850(G)(1)(c). • Expedited reviews are not required for Retrospective Adverse Health Care Treatment Decisions. • Expedited review of Concurrent Review Determination of emergency services or of an initially authorized admission or course of treatment, the service shall be continued without liability to the covered person until the covered person has been notified of the decision. **An Adverse Health Care Treatment Decision Notice shall include:** • The principal reason or reasons for the decision; • Reference to the specific plan provisions on which the decision is based; • Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request; • A description of any additional material or information necessary for the covered person to perfect the • claim and an explanation as to why such material or information is necessary; • The instructions and time limits for initiating an appeal or reconsideration of the decision; • If the adverse health care treatment decision is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either: o An explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant's medical circumstances,		

		○ Or a statement that such an explanation will be provided free of charge upon request; • What criterion was relied upon in making the adverse health care treatment decision, provide either: ○ The specific rule, guideline, protocol, or other similar criterion, or ○ A statement referring to the rule, guideline, protocol, or ○ Other similar criterion that was relied upon in making the adverse decision; and ○ Explain that a copy will be provided free of charge to the covered person upon request; • Phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rationale and review criteria; • Description of the expedited review process applicable to claims involving urgent care; • Availability of any applicable office of health insurance consumer assistance or ombudsman • established under the federal Affordable Care Act; • Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto; and • Any other information required pursuant to the federal Affordable Care Act. • The carrier or the carrier's designated URE shall respond expeditiously to requests for information. **<u>Second Level Appeals of Adverse Health Care Treatment Decisions:</u>** • Shall provide the opportunity for a second level appeal to covered persons who are dissatisfied with a first level appeal decision.		

		• Persons covered under individual health insurance plans must be notified of the right to request an external review without exhausting the carrier's second level appeal process.
		  o The same notice may be given to persons covered under group plans if the carrier permits them to bypass the second level of appeal.
		• The carrier shall appoint a panel for each second level appeal, which shall include one or more panelists who are disinterested clinical peers.
		• A second level appeal decision adverse to the covered person must have the concurrence of a majority of the disinterested clinical peers on the panel.
		• If the covered person has requested to appear in person the procedures for conducting a second level panel review shall include the following:
		  o The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review.
		  ▪ The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person.
		  ▪ The health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology.
		  ▪ The covered person shall be notified in writing at least 15 days in advance of the review date.
		  ▪ The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.
		• Upon the request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential and privileged from disclosure to the covered person.
		• A covered person has the right to:
		  o Attend the second level review;
		  o Present his or her case to the review panel;		

		○ Submit supporting material both before and at the review meeting; ○ Ask questions of any representative of the health carrier; ○ Be assisted or represented by a person of his or her choice; and ○ Obtain his or her medical file and information relevant to the appeal free of charge upon request. • If the insurer will have an attorney present to argue its case against the covered person: ○ The carrier shall so notify the covered person at least 15 days in advance of the review, and ○ Advise the covered person of his or her right to obtain legal representation. • The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review. • The review panel shall: ○ Issue a written decision to the covered person within 5 working days after completing the review meeting. ○ A decision adverse to the covered person shall include the requirements set forth in Rule 850 subparagraph 8(G)(1)(c). **An Adverse Health Care Treatment Appeal Decision shall contain:** • The names, titles and qualifying credentials of the person or persons evaluating the appeal; • A statement of the reviewers' understanding of the reason for the covered person's request for an appeal; • Reference to the specific plan provisions upon which the decision is based; • The reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position; • A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. ○ The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including		

		any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. o Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse decision, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision. • The criterion that was relied upon in making the adverse health care treatment decision, provide either: o The specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or o Other similar criterion that was relied upon in making the adverse decision; o Explain that a copy will be provided free of charge to the covered person upon request. • Notice of any subsequent appeal rights, and the procedure and time limitation for exercising those rights: o Notice of external review rights must be provided to the enrollee as required by 24-A M.R.S.A. §4312(3). o A description of the process for submitting a written request for second level appeal must include the rights specified in Rule 850 subsection G-1. • Notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act. • Notice of the covered person's right to contact the Superintendent's office. The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance. Any other information required pursuant to the federal Affordable Care Act. **<u>Adverse Benefit Determinations not Involving Adverse Health Care Treatment Decisions</u>**		

		Notice of Adverse Benefit Determinations not Involving Health Care Treatment Decisions: • Any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes: • Principal reason or reasons for the determination; • Reference to the specific plan provisions on which the determination is based; • Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and ○ A statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request; • Description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material or information is necessary; • Instructions and time limits for initiating an appeal or reconsideration of the determination; • Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto. • Provide the criterion that was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol and explain that a copy will be provided free of charge to the covered person upon request; • Phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria; • Description of the expedited review process applicable to claims involving urgent care;		

		• Availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act; and
		• Any other information required pursuant to the federal Affordable Care Act.
		
		First Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions:
		
		• A grievance concerning any matter may be submitted by a covered person or a covered person's representative.
		• The carrier shall make these rights known to the covered person within 3 working days after receiving a grievance.
		  o The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier.
		  o A covered person does not have the right to attend, or to have a representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer.
		  o The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance.
		• Carrier shall issue a written decision to the covered person within 30 days after receiving a grievance.
		  o Additional time is permitted where the carrier can establish the 30-day time frame cannot reasonably be met due to the carrier's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier.
		  o The carrier shall provide written notice of the delay to the covered person. The notice shall explain the reasons for the delay.
		  o In such instances, decisions must be issued within 30 days after the carrier's receipt of all necessary information.
		
		An Adverse Benefit Determination Decision Notice shall contain:		

		• The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process. • Statement of the reviewers' understanding of the covered person's grievance and all pertinent facts. • Reference to the specific plan provisions on which the benefit determination is based. • The reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination. • Reference to the evidence or documentation used as the basis for the decision. • The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person. • What criterion was relied upon in making the adverse benefit determination, provide either: o The specific rule, guideline, protocol, or other similar criterion, or o A statement referring to the rule, guideline, protocol, or o Other similar criterion that was relied upon in making the adverse determination; and o Explain that a copy will be provided free of charge to the covered person upon request; • Description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the rights specified in subparagraph C(3)(c). • Notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S.A. §4312(3). • Notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act. • Notice of the covered person's right to contact the Superintendent's office. The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance.		

		• Any other information required pursuant to the federal Affordable Care Act. **Second Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions:** • The carrier shall provide a second level grievance review process to covered persons who are dissatisfied with a first level grievance review determination under subsection B. • The covered person has the right to appear in person before authorized representatives of the health carrier, and shall be provided adequate notice of that option by the carrier. • The carrier shall appoint a second level grievance review panel for each grievance subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the health carrier who were not previously involved in the grievance. • Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a second level panel review shall include the following: o The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review. o The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. o The carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. o The covered person shall be notified in writing at least 15 days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. • Upon the request of a covered person, a health carrier shall provide to the covered person, free of charge, all relevant information that		

		is not confidential and privileged from disclosure to the covered person.
		• A covered person has the right to:
		  ○ Attend the second level review;
		  ○ Present his or her case to the review panel;
		  ○ Submit supporting material both before and at the review meeting;
		  ○ Ask questions of any representative of the health carrier; and
		  ○ Be assisted or represented by a person of his or her choice.
		• If the carrier will have an attorney present to argue its case against the covered person, the carrier shall so notify the covered person at least 15 days in advance of the review, and shall advise the covered person of his or her right to obtain legal representation.
		• The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.
		The review panel shall issue a written decision to the covered person within 5 working days after completing the review meeting. A decision adverse to the covered person shall include the information specified in Rule 850 subparagraph B(2)(b).		

Right to waive the right to a second level appeal/grievance	24-A M.R.S.A. §4312	Enrollees have the right to waive the right to a second level appeal/grievance and request an external review after the first level appeal decision.	☐	
Timeline for second level grievance review decisions	24-A M.R.S.A. §4303(4) Rule 850	Decisions for second level grievance reviews must be issued within 30 calendar days. If the insured has requested to appear in person before authorized representatives of the health carrier the decision must be issued within 45 calendar days.	☐	
PROVIDERS/NETWORKS				
Acupuncture services	24-A M.R.S.A. §2837-B	Benefits must be made available for the services of acupuncturist if comparable services would be covered if performed by a physician. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
Certified nurse practitioners and	24-A M.R.S.A. §4248	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serve as primary care providers.	☐	

certified nurse midwifes (aka: Advanced Practice Registered Nurse)				
Chiropractic Services /Manipulative Therapy	24-A M.R.S.A. §4236	Provide benefits for care by chiropractors at least equal to benefit paid to other providers treating similar neuro-musculoskeletal conditions. Must provide clarification how physical therapy, occupational therapy and osteopathic benefits are applied when chiropractic services are provided. Therapeutic, adjustive and manipulative services (including but not limited to chiropractic services) shall be covered as follows: 1. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor. 2. Benefits for care by chiropractors must be at least equal to benefit paid to other providers treating similar neuro-musculoskeletal conditions. This does not require identical cost sharing by provider type. 3. Visit limits on therapeutic, adjustive and manipulative services will be permitted only if any such limits apply regardless of provider type. 4. Policies must clearly explain how physical therapy, occupational therapy and other types of services are covered when those services are provided by a chiropractor acting within the scope of the chiropractor's license. Policies must clearly explain how therapeutic, adjustive and manipulative services are covered when those services are provided by physicians other than a chiropractor.	☐	
Clinical professional counselors	24-A M.R.S.A. §4234-A(8)	Must include benefits for licensed clinical professional counselor services to the extent that the same services would be covered if performed by a physician.	☐	
Dentists	24-A M.R.S.A. §2437	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician. ***(There is no***	☐	

		specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)		
Enrollee choice of PCP	24-A M.R.S.A. §4306	A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A to serve as primary care providers for managed care plans.	☐	
Essential Health Care Providers (Rural health clinics)	Rule 850(7)	Benefits must be made available for outpatient health care services of certified rural health clinics.	☐	
Independent Practice Dental Hygienists	24-A M.R.S.A. §4257	Coverage must be provided for dental services performed by a licensed independent practice dental hygienist when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist.	☐	
Naturopathic doctor	24-A MRSA §4320-K	Must provide coverage for health care services performed by a naturopathic doctor licensed in this State when those services are covered services under the plan when performed by any other health care provider **and** those services are within the lawful scope of practice of the naturopathic doctor. Any deductible, copayment or coinsurance cannot exceed the deductible, copayment or coinsurance applicable to the same service provided by other health care providers. **Network participation:** • A carrier must demonstrate that its provider network includes reasonable access to all covered services that are within the lawful scope of practice of a naturopathic doctor.	☐	

		• A carrier may not exclude a provider from network participation solely because the provider is a naturopathic doctor, as long as the provider is willing to meet the same terms and conditions as other participating providers. • A carrier is not required to contract with all naturopathic doctors. A carrier is not required to provide coverage for any service provided by a participating naturopathic doctor that is not within the plan's scope of coverage.		
Network adequacy	24-A M.R.S.A. §2673-A §4303(1) Rule 850(7) Rule 360	All managed care arrangements except MEWA's must be filed for adequacy and compliance with Rule 850 and Rule 360 access standards. If the policy uses a network, the network(s) need to have been approved by the Bureau for adequacy and access standards (i.e. physician, hospital, and ancillary service networks). Must provide a copy of network approval.	☐	
Pastoral counselors and marriage and family therapists	24-A M.R.S.A. §4234-A (8)	Must include benefits for licensed pastoral counselors and marriage and family therapists for mental health services to the extent that the same services would be covered if performed by a physician.	☐	
Pharmacy Providers – "Any Willing Pharmacy"	24-A M.R.S.A. §4317	A carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers.	☐	
PPOs – Payment for Non-preferred Providers	24-A M.R.S.A. §2677-A(2)	The benefit level differential between services rendered by preferred providers and non-preferred providers may not exceed 20% of the allowable charge for the service rendered.	☐	
Provider directories	24-A M.R.S. §4303-D	**1. Requirement.** A carrier shall make available provider directories in accordance with this section. A. A carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search	☐	

		functions described in subsection 2. In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number. B. A carrier shall update each provider directory at least monthly. The carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the superintendent upon request. C. A carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in subsection 2 upon request of a covered person or a prospective covered person. D. For each network plan, a carrier shall include in plain language in both the electronic and print directories the following general information: (1) A description of the criteria the carrier has used to build its provider network; (2) If applicable, a description of the criteria the carrier has used to tier providers; (3) If applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network the tier in which each is placed, whether by name, symbols, grouping or another designation, so that a covered person or a prospective covered person is able to identify the provider tier; and (4) If applicable, that authorization or referral may be required to access some providers. E. A carrier shall make clear in both its electronic and print directories which provider directory applies to which network plan by including the specific name of the network plan as marketed and issued in this State. The carrier shall include in both its electronic and print directories a customer service e-mail address and telephone number or		

		electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information. F. For the information required pursuant to subsections 2, 3 and 4 in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, a carrier shall make available through the directory the source of the information and any limitations on the information, if applicable. G. A provider directory, whether in electronic or print format, must accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency. **2. Information in searchable format.** A carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format: A. For health care professionals: (1) The health care professional's name; (2) The health care professional's gender; (3) The participating office location or locations; (4) The health care professional's specialty, if applicable; (5) Medical group affiliations, if applicable; (6) Facility affiliations, if applicable; (7) Participating facility affiliations, if applicable; (8) Languages other than English spoken by the health care professional, if applicable; and (9) Whether the health care professional is accepting new patients; B. For hospitals: (1) The hospital's name; (2) The hospital's type; (3) Participating hospital location; and (4) The hospital's accreditation status. C. For facilities, other than hospitals, by type:		

		(1) The facility's name; (2) The facility's type; (3) Types of services performed; and (4) Participating facility location or locations. **3. Additional information.** In the electronic provider directories for each network plan, a carrier shall make available the following information in addition to all of the information available under subsection 2: A. For health care professionals: (1) Contact information; (2) Board certifications; and (3) Languages other than English spoken by clinical staff, if applicable; B. For hospitals, the telephone number; and C. For facilities other than hospitals, the telephone number.. **4. Information available in printed form.** A carrier shall make available in print, upon request, the following provider directory information for the applicable network plan: A. For health care professionals: (1) The health care professional's name; (2) The health care professional's contact information; (3) Participating office location or locations; (4) The health care professional's specialty, if applicable; (5) Languages other than English spoken by the health care professional, if applicable; and (6) Whether the health care professional is accepting new patients; B. For hospitals: (1) The hospital's name; (2) The hospital's type; and (3) Participating hospital location and telephone number; and		

		C. For facilities, other than hospitals, by type: (1) The facility's name; (2) The facility's type; (3) Types of services performed; and (4) Participating facility location and telephone number. The carrier shall include a disclosure in the directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website to obtain current provider directory information.		
Psychologists' services	24-A M.R.S.A. §2835	Must include benefits for psychologists' services to the extent that the same services would be covered if performed by a physician. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
Registered nurse first assistants	24-A M.R.S.A. §4246	Benefits must be provided for coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications.	☐	
Social workers/Psychiatric nurses	24-A M.R.S.A. §2835	Benefits must be included for the services of social workers and psychiatric nurses to the extent that the same services would be covered if performed by a physician. ***(There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.)***	☐	
GENERAL HEALTH CARE SERVICES/COVERAGE - ***PLEASE NOTE: ALL BENEFITS MUST BE LISTED IN THE POLICY/CERTIFICATE AND SCHEDULE OF BENEFITS.***				
Anesthesia for Dentistry	24-A M.R.S.A. §4251	Anesthesia & associated facility charges for dental procedures are mandated benefits for certain vulnerable persons.	☐	
Coverage for breast cancer treatment	24-A M.R.S.A. §4237	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes.	☐	
Breast reduction and symptomatic varicose vein surgery	24-A M.R.S.A. §4252	Coverage must be offered for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary	☐	

Chiropractic Services /Manipulative Therapy	24-A M.R.S.A §4236(3)	Requires treatment for acute care for a limited self-referred for chiropractic benefits. Must provide clarification how physical therapy, occupational therapy and osteopathic benefits are applied when chiropractic services are provided.	☐	
Clinical Trials	24-A M.R.S.A. §4310	Provide access to clinical trials pursuant to: 1. Qualified enrollee**.** An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions: A. The enrollee has a life-threatening illness for which no standard treatment is effective; B. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness; C. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and D. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C. 2. Coverage. A carrier may not deny a qualified enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. For the purposes of this section, "routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved. 3. Payment. A carrier shall provide payment for routine patient costs but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial. In the case of covered items and services, the carrier shall pay participating providers at the agreed upon rate and pay	☐	

		nonparticipating providers at the same rate the carrier would pay for comparable services performed by participating providers. 4. Approved clinical trial. For the purposes of this section, "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health. 5. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. A non-grandfathered health plan may not discriminate on the basis of participation in a clinical trial and must cover routine patient costs of individuals in clinical trials for treatment of cancer or other life-threatening conditions.		
Colorectal Cancer Screening	24-A M.R.S.A. §4254 §4320-A	Coverage must be provided for colorectal cancer screening (including colonoscopies if recommended by a health care provider as the colorectal cancer screening test) for asymptomatic individuals who are fifty years of age or older; or less than 50 years of age and at high risk for colorectal cancer. If a colonoscopy is recommended as the colorectal cancer screening and a lesion is discovered and removed during the colonoscopy benefits must be paid for the screening colonoscopy as the primary procedure. Must clearly disclose preventive screenings vs diagnostic services.	☐	
Emergency Services	24-A M.R.S.A. §4320-C	The plan must cover emergency services in accordance with the requirements of the ACA, including requirements that emergency services be covered without prior authorization and that cost-sharing requirements, expressed as a copayment amount or coinsurance rate,	☐	

	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138) SSA §1395dd Rule 191, Sec. 9(M)	for out-of-network services are the same as requirements that would apply if such services were provided in network. Cannot require prior authorization; cannot be limited to only services and care at participating providers; must be covered at in-network cost-sharing level (patient is not penalized for emergency care at out of network provider); Must pay for out-of-network emergency services the greatest of: (1) the median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out of-network services); or (3) the Medicare rate. If emergency care is required, ambulance transportation to the nearest contracted facility or to the nearest non-contracted facility capable of providing necessary care.		
Essential health benefits	24-A M.R.S.A. §4320-D Rule 191, Sec. 9(M)	A carrier offering a health plan subject to the requirements of the federal ACA shall, at a minimum, provide coverage that incorporates essential benefits and cost-sharing limitations consistent with the requirements of the federal ACA.	☐	
Eye Care Services	24-A M.R.S.A. §4314	Patient access to eye care providers when the plan provides eye care services.	☐	
HIV/AIDS	24-A M.R.S.A. §4229	May not provide more restrictive benefits for expenses resulting from Acquired Immune Deficiency Syndrome (AIDS) or related illness.	☐	
Home health care coverage	24-A M.R.S.A. §2837 Rule 191, Sec. 9(M)	Every insurer which issues or issues for delivery in this State individual health policies, which provide coverage on an expense incurred basis for inpatient hospital care, shall make available such coverage for home health care services by a home health care provider Home health care by an accredited agency under a written plan by a physician, or other licensed provider such as a Nurse Practitioner or	☐	

		Physician Assistant, working within the provider's scope of practice, for a minimum of 90 visits per calendar year.		
Hospice Care Services	24-A M.R.S.A. §4250	Hospice care services must be provided to a person who is terminally ill (life expectancy of 12 months or less). Must be provided whether the services are provided in a home setting or an inpatient setting. See section for further requirements.	☐	
Leukocyte Antigen Testing To Establish Bone Marrow Donor	24-A M.R.S.A. § 4320-I	A carrier offering a health plan in this State shall provide coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements: A. The enrollee covered under the health plan must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization; B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a; C. At the time of the testing, the enrollee covered under the health plan must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; and D. The carrier may limit each enrollee to one test per lifetime. Prohibition on cost-sharing. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for the coverage required under this section.	☐	

Naturopathic services	24-A M.R.S. § 4320-K	Must provide coverage for health care services performed by a naturopathic doctor licensed in this State when those services are covered services under the plan when performed by any other health care provider **and** those services are within the lawful scope of practice of the naturopathic doctor. Any deductible, copayment or coinsurance cannot exceed the deductible, copayment or coinsurance applicable to the same service provided by other health care providers.	☐	
Preventive health services Preventive health services without cost-sharing requirements including deductibles, co-payments, and co-insurance.	24-A M.R.S.A. §4320-A Rule 191, Sec. 9(M) PHSA §2713 (75 Fed Reg 41726, 45 CFR §147.130)	Must, at a minimum, provide coverage for, and may not impose cost-sharing requirements for, the following preventive services: • The evidence-based items or services that have a rating of A or B in the recommendations of the USPSTF or equivalent rating from a successor organization; • With respect to the individual insured, immunizations that have a recommendation from the federal DHHS, CDC, Advisory Committee on Immunization Practices; • With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal DHHS, HRSA; and • With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal DHHS, HRSA women's preventive services guidelines. If one of the recommendations referenced above is changed during a plan year, a carrier is not required to make changes to that health plan during the plan year.	☐	
Prostate cancer screening	24-A M.R.S.A. §4244 §4320-A	Coverage required for prostate cancer screening: Digital rectal examinations and prostate-specific antigen tests covered if recommended by a physician, at least once a year for men 50 years of age or older until age 72.	☐	

Reconstructive surgery after mastectomy	24-A M.R.S.A. §4237 PHSA §2727	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes. If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient. Coverage must include: • Reconstruction of the breast on which the mastectomy was performed (all stages); • Surgery and reconstruction of the other breast to produce symmetrical appearance; • Prostheses; and • Treatment of physical complications at all stages of mastectomy. **PHSA §2727 does not limit mastectomy to cancer diagnosis.**	☐	
Telemedicine Services	24-A M.R.S.A. §4316	A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.	☐	
WOMAN & MATERNITY - ***PLEASE NOTE: ALL BENEFITS MUST BE LISTED IN THE POLICY/CERTIFICATE AND SCHEDULE OF BENEFITS.***				
Mammogram screening	24-A M.R.S.A. §4237-A §4320-A	If radiological procedures are covered. Benefits must be made available for screening mammography at least once a year for women 40 years of age and over. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.	☐	

Maternity & routine newborn care Maternity coverage (see EHB) and required benefits for hospital stays in connection with childbirth	24-A M.R.S.A. §2743-A PHSA §2725 (45 CFR §148.170)	Benefits must be provided for maternity (length of stay) and routine newborn care, in accordance with "Guidelines for Perinatal Care" as determined by attending provider and mother. **Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section.** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother.	☐	
Maternity benefits for unmarried women	24-A M.R.S.A. §4234(2)	Maternity benefits must be made available to unmarried women on the same basis as married women.	☐	
Obstetrical and Gynecological services	24-A M.R.S.A. §4241 Rule 191, Sec. 9(M) §4306-A PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138)	Benefits must be provided for annual gynecological exam without prior approval of primary care physician. A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.	☐	
Pap tests	24-A M.R.S.A. §4242 §4320-A	Benefits must be provided for cervical cancer screening tests.	☐	

INFANTS & CHILDREN - ***PLEASE NOTE: ALL BENEFITS MUST BE LISTED IN THE POLICY/CERTIFICATE AND SCHEDULE OF BENEFITS.***				
Autism Spectrum Disorders	24-A M.R.S.A. §4259	All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under a policy, contract or certificate in accordance with the following. **1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings. A. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified. C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder: (1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts; (2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and (3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.	☐	

		2. Required Coverage. A. The policy, contract or certificate must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder. B. The policy, contract or certificate must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary. C. The policy, contract or certificate may limit coverage for applied behavior analysis to the actuarial equivalent of $36,000 worth of visits/services per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph. D. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition. **If visits/services are limited it must be actuarially equivalent to $36,000 and you must provide actuarial justification with the filing.**		
Early Childhood Intervention	24-A M.R.S.A. §4258	All group and individual health insurance policies, contracts and certificates must provide coverage for children's early intervention services in accordance with this subsection. A referral from the child's primary care provider is required. The policy or contract may limit coverage to the actuarial equivalent of $3,200 worth of visits/services per year for each child not to exceed the actuarial equivalent of $9,600 worth of visits/services by the child's 3rd birthday. **If visits/services are limited it must be actuarially equivalent to $3,200 and you must provide actuarial justification with the filing.** “Children's early intervention services” means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or	☐	

		delay as described in the federal Individuals with Disabilities Education Act, Part C, 20, United States Code, Section 1432 at http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title20-section1432&num=0&edition=prelim. The following federal definition is provided for your information and is not required to be included in the policy/certificate: **(4) Early intervention services** The term "early intervention services" means developmental services that- (A) are provided under public supervision; (B) are provided at no cost except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees; (C) are designed to meet the developmental needs of an infant or toddler with a disability, as identified by the individualized family service plan team, in any 1 or more of the following areas: (i) physical development; (ii) cognitive development; (iii) communication development; (iv) social or emotional development; or (v) adaptive development; (D) meet the standards of the State in which the services are provided, including the requirements of this subchapter; (E) include- (i) family training, counseling, and home visits; (ii) special instruction; (iii) speech-language pathology and audiology services, and sign language and cued language services; (iv) occupational therapy; (v) physical therapy; (vi) psychological services; (vii) service coordination services; (viii) medical services only for diagnostic or evaluation purposes; (ix) early identification, screening, and assessment services; (x) health services necessary to enable the infant or toddler to benefit from the other early intervention services;		

		(xi) social work services; (xii) vision services; (xiii) assistive technology devices and assistive technology services; and (xiv) transportation and related costs that are necessary to enable an infant or toddler and the infant's or toddler's family to receive another service described in this paragraph; (F) are provided by qualified personnel, including- (i) special educators; (ii) speech-language pathologists and audiologists; (iii) occupational therapists; (iv) physical therapists; (v) psychologists; (vi) social workers; (vii) nurses; (viii) registered dietitians; (ix) family therapists; (x) vision specialists, including ophthalmologists and optometrists; (xi) orientation and mobility specialists; and (xii) pediatricians and other physicians; (G) to the maximum extent appropriate, are provided in natural environments, including the home, and community settings in which children without disabilities participate; and (H) are provided in conformity with an individualized family service plan adopted in accordance with section 1436 of this title.		
Hearing aids	24-A M.R.S.A. §4255	Coverage is required for the purchase of hearing aids for each hearing-impaired ear for the following individuals: A. From birth to 5 years of age if the individual is covered under a policy or contract that is issued or renewed on or after January 1, 2008. B. From 6 to 13 years of age if the individual is covered under a policy or contract that is issued or renewed on or after January 1, 2009.	☐	

		C. From 14 to 18 years of age if the individual is covered under a policy or contract that is issued or renewed on or after January 1, 2010. The policy or contract may limit coverage to the actuarial equivalent of $1,400 per hearing aid for each hearing-impaired ear every 36 months. **Must provide actuarial justification that the visits/services per year are equivalent to $1,400 per hearing aid for each hearing-impaired ear every 36 months.**		
Infant Formula	24-A M.R.S.A. §4256 §2847-P	Coverage of amino acid-based elemental infant formula must be provided when a physician has diagnosed and documented one of the following: A. Symptomatic allergic colitis or proctitis; B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; C. A history of anaphylaxis D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider F. Cystic fibrosis; or G. Malabsorption of cow milk-based or soy milk-based formula Medical necessity is determined when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. Coverage for amino acid-based elemental infant formula under a policy, contract or certificate issued in connection with a health savings account may be subject to the same deductible and out-of-	☐	

		pocket limits that apply to overall benefits under the policy, contract or certificate.		
Medical food coverage for inborn error of metabolism	24-A M.R.S.A. §4238	Must provide coverage for metabolic formula and up to the actuarial equivalent of $3,000 per year for prescribed modified low-protein food products.	☐	
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES/COVERAGE				
Mental health coverage	24-A M.R.S.A. §4234-A §4320-D Rule 191, Sec. 9(M)	Federal and State mental health parity requirements both apply. Benefits (including financial requirements and treatment limitations) cannot be less extensive than for physical illnesses. The following is only a partial list of the types of conditions that cannot be excluded: psychotic disorders (including schizophrenia), dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, attention deficit ad disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders (including bulimia and anorexia), and substance abuse-related disorders.	☐	
Mental health parity and substance use disorder benefits	PHSA §2726 (45 CFR 156.115(a)(2)) ACA 1563(a)(4)	Extends mental health parity requirements into EHB for nongrandfathered individual and small group plans.	☐	
Mental health services provided by counseling professionals.	24-A M.R.S.A. §4234-A(8-A)	Benefits must be made available for mental health services provided by licensed counselors.	☐	
PRESCRIPTION DRUGS				
Abuse-deterrent opioid analgesic drug products	24-A M.R.S.A. §4320-J	A carrier offering a health plan in this State shall provide coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan.	☐	

		An increase in enrollee cost sharing to achieve compliance with this section may not be implemented. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings. A. "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration with abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse. B. "Cost sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense associated with a health plan. C. "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release, long-acting form and whether or not combined with other drug substances to form a single drug product or dosage form.		
Continuity of Prescription Drugs	24-A M.R.S.A. §4303(7)(A)	If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee's coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. Policies must include a notice of the carrier's right to request a review with the enrollee's provider, and the replacing carrier must honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.	☐	

Contraceptives	24-A M.R.S.A. §4247 §4320-A	All contracts that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services. Coverage required under this section must include coverage for contraceptive supplies in accordance with the following requirements. For purposes of this section, "contraceptive supplies" means all contraceptive drugs, devices and products approved by the federal Food and Drug Administration to prevent an unwanted pregnancy. A. Coverage must be provided without any deductible, coinsurance, copayment or other cost-sharing requirement for at least one contraceptive supply within each method of contraception that is identified by the federal Food and Drug Administration to prevent an unwanted pregnancy and prescribed by a health care provider. B. If there is a therapeutic equivalent of a contraceptive supply within a contraceptive method approved by the federal Food and Drug Administration, an insurer may provide coverage for more than one contraceptive supply and may impose cost-sharing requirements as long as at least one contraceptive supply within that method is available without cost sharing. C. If an individual's health care provider recommends a particular contraceptive supply approved by the federal Food and Drug Administration for the individual based on a determination of medical necessity, the insurer shall defer to the provider's determination and judgment and shall provide coverage without cost sharing for the prescribed contraceptive supply. D. Coverage must be provided for the furnishing or dispensing of prescribed contraceptive supplies intended to last for a 12-month period, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider.for other prescription drugs or outpatient medical services.	☐	

Diabetes supplies	24-A M.R.S.A. §4240	Benefits must be provided for medically necessary equipment and supplies used to treat diabetes (insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets) and approved self-management and education training authorized by the State's Diabetes Control Project within the Maine Bureau of Health.	☐	
Drug Mail Order Opt Out	45 CFR §156.122(e)	A health plan that provides an essential health benefits (EHB) package cannot have a mail-order only prescription drug benefit.	☐	
Early refills of prescription eye drops	24-A M.R.S.A. §4314-A	A carrier offering a health plan in this State shall provide coverage for one early refill of a prescription for eye drops if the following criteria are met: A. The enrollee requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed; B. The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized; C. The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription; D. The prescription has not been refilled more than once during the period authorized by the prescribing health care provider prior to the request for an early refill; and E. The prescription eye drops are a covered benefit under the enrollee's health plan. 2. Cost sharing. A carrier may impose a deductible, copayment or coinsurance requirement for an early refill under this section as permitted under the health plan.	☐	
Exception Process & External Exception Review	45 CFR 156.122(c)(1)	A health plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.	☐	

	45 CFR 156.122(c)(2)	**Standard Exception Process**: Such procedures must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request a standard of a coverage decision for a drug that is not covered by the plan. (i) A health plan must make its coverage determination on a standard review request based on standard review of a coverage decision and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours after it receives the request. (ii) A health plan that grants an exception based on a standard review process must provide coverage of the non-formulary drug for the duration of the prescription, including refills. **Expedited Exception Process**: Such procedures must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances. (i) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. (ii) A health plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours after it receives the request.		

	45 CFR §156.122(c)(3)	(iii) A health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency. **External Exception Review**: If the health plan denies an exception request for a non-formulary drug, the issuer must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request that an independent review organization review the exception request and the denial of that request by the plan. (i) The independent review organization would have to make its determination and the health plan would have to notify the enrollee or enrollee's designee and the prescribing physician (or other prescriber, as appropriate) no later than 72 hours after the time it receives the external exception review request. (ii) If the initial exception request is for an expedited review and that request is denied by the plan, then the independent review organization would have to make its coverage determination and provide appropriate notification no later than 24 hours after the time it receives the external exception review request.		
Information about prescription drugs	24-A MRSA §4303, sub-§20	Consistent with the requirements of the federal Affordable Care Act, a carrier offering a health plan in this State shall provide the following information to prospective enrollees and enrollees with respect to prescription drug coverage on its publicly accessible website. A. A carrier shall post each prescription drug formulary for each health plan offered by the carrier. The prescription drug formularies must be posted in a manner that allows prospective enrollees and enrollees to search the formularies and compare formularies to determine whether a particular prescription drug is covered under a formulary. When a change is made to a formulary, the updated formulary must be posted on the website within 72 hours.	☐	

		B. A carrier shall provide an explanation of: (1) The requirements for utilization review, prior authorization or step therapy for each category of prescription drug covered under a health plan; (2) The cost-sharing requirements for prescription drug coverage, including a description of how the costs of prescription drugs will specifically be applied or not applied to any deductible or out-of-pocket maximum required under a health plan; (3) The exclusions from coverage under a health plan and any restrictions on use or quantity of covered health care services in each category of benefits; and (4) The amount of coverage provided under a health plan for out-of-network providers or noncovered health care services and any right of appeal available to an enrollee when out-of-network providers or noncovered health care services are medically necessary.		
Off-label use of prescription drugs for cancer, HIV or AIDS	24-A M.R.S.A. §4234-D §4234-E	Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.	☐	
Orally Administered Cancer Therapy	24-A M.R.S.A. §4317-B	1. Coverage. A carrier that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications. An increase in patient cost sharing for anticancer medications may not be used to achieve compliance with this section. 2. Construction. This section may not be construed to prohibit or limit a carrier's ability to establish a prescription drug formulary or to require a carrier to cover an orally administered anticancer medication	☐	

		on the sole basis that it is an alternative to an intravenously administered or injected anticancer medication. Sec. 2. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.		
Prescription Drug Access	24-A M.R.S.A. §4311	Access to prescription drugs for contracts that provide coverage for prescription drugs and medical devices.	☐	
Prescription drug formulary: Exceptions to formulary and Notice of adverse change to formulary	24-A M.R.S. § 4311(1)	The following requirements apply if a plan limits prescription drug coverage to drugs in a formulary: **Exceptions:** must allow exceptions to the formulary when a nonformulary alternative is medically indicated consistent with the UR standards in §4303. **Notice of adverse change:** must provide at least 60 days' written notice to an enrollee of an adverse change to a formulary; less than 60 days' notice is allowed when a drug is being removed from the formulary due to safety concerns • "adverse change to a formulary" means a change that removes a drug currently prescribed for that enrollee from the formulary applicable to the enrollee's health plan **or** a change that moves the prescribed drug to a tier with a higher cost-sharing requirement if the carrier uses a formulary with tiers • Notice must use conspicuous font • Notice must inform enrollee of the change **and** advise enrollee to consult with provider about the change • If a drug is removed from a formulary, must notify an enrollee affected by the change of the ability to request an exception **and** provide a form for requesting exception ○ If an enrollee has already received prior authorization for the drug, must continue to honor the authorization until it expires, as long as the enrollee continues to be covered under the same plan and the drug has not been removed due to safety concerns		

		• If a drug has been removed from a formulary (except if removed due to safety concerns), and an exception request is received prior to the effective date of the change, must continue to cover the drug until a decision is reached on the exception request.		
Prescription synchronization	24-A M.R.S.A. §2769	If a health plan provides coverage for prescription drugs, a carrier: A. Shall permit and apply a prorated daily cost-sharing rate to a prescription that is dispensed by a pharmacist in the carrier's network for less than a 30-day supply if the prescriber or pharmacist determines that filling or refilling the prescription for less than a 30-day supply is in the best interest of the patient and the patient requests or agrees to less than a 30-day supply in order to synchronize the refilling of that prescription with the patient's other prescriptions; B. May not deny coverage for the dispensing of a medication prescribed for the treatment of a chronic illness that is made in accordance with a plan developed by the carrier, the insured, the prescriber and a pharmacist to synchronize the filling or refilling of multiple prescriptions for the insured. The carrier shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon in order to synchronize the patient's prescriptions; and C. May not use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions must be paid in full for each prescription dispensed, regardless of any prorated copay for the insured or fee paid for alignment services. 2. Application; exclusion. The requirements of this section do not apply to a prescription for: A. Solid oral doses of antibiotics; or B. Solid oral doses that are dispensed in their original container as indicated in the federal Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to	☐	

		assist a patient with compliance.		
Prosthetic devices to replace an arm or leg.	24-A M.R.S.A. §4315	Coverage must be provided, at a minimum, for prosthetic devices to replace, in whole or in part, an arm or leg to the extent that they are covered under the Medicare program. Coverage for repair or replacement of a prosthetic device must also be included. Exclusion for micro-processors was removed effective 1/2011. 1. Definition. As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg. 2. Required coverage. A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee. 8. Health savings accounts. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.	☐	
	42 USC 1395m	(h) Payment for prosthetic devices and orthotics and prosthetics (1) General rule for payment (A) In general Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).		

		(B) Payment basis Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of— (i) the actual charge for the item; or (ii) the amount recognized under paragraph (2) as the purchase price for the item. **Coverage should be applied as follows:** 1. Coinsurance shall NOT exceed 20%, AFTER deductible in the plan. 2. HSA's are NOT subject to the 20% requirement but coinsurance may not exceed that for other services. 3. DME and other prosthetic devices are NOT subject to the 20%, so it would be helpful to clarify in the schedule of benefits, summary of benefits and coverage, and the plan and benefits template how each category is paid out. 4. Out Of Network is NOT subject to 20%, unless there is no in-network available then OON should be billed as in-network i.e. 20%.		
Specialty tiered drugs - Adjustment of out-of-pocket limits	24-A M.R.S.A. §4317-A	A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section. Any adjustment made by a carrier pursuant to this subsection is considered a minor modification under section 2850-B.	☐	
Third Party Prescription Act (Any Willing Pharmacy)	32 M.R.S.A. §13771 24-A M.R.S.A. §4317 Bulletin 377	A carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers.	☐	